DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45 3/29/14

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	446303	A. BUILDING _____ B. WING _____	02/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the privacy of one resident (#7) during one of two medication administration passes observed. The findings included:	F 164	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." F 164 1. Resident #7 record was immediately covered and protected 2. Residents residing in facility have the potential to be affected by the alleged deficient practice. 3. In-service/re-education for nursing staff by DON, Unit mangers and nursing supervisor to include covering of MARS and other resident specific information. 4. Unit manager and nursing supervisor will perform walk through observations during medication pass times 3 times a week on random shifts to include each shift. Reports of observations will be discussed in QAPI meeting x 3 months. Those attending will be Administrator, DON, Unit manager, Medical director, social services and other department head members as needed.	03/14/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3-5-2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 Observation with Licensed Practical Nurse (LPN) #2 on February 10, 2014, at 8:45 a.m., on the 100 hallway, revealed LPN #2 prepared medications at the medication cart, using the Medication Administration Record (MAR) to identify the resident and the prescribed medications to be administered. Continued observation revealed LPN #2 left the MAR open and unattended on top of the cart, exposing the resident's personal information, and entered the resident's room to administer the medication. Interview with LPN #2 on February 10, 2014, at 8:57 a.m., in the hallway, confirmed the resident's information on the MAR was to be covered before leaving the cart, and the resident's privacy had not been maintained.	F 164	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to accommodate preferences for one resident (#67) of thirty residents reviewed.	F 242	F 242 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident # 67. Resident has been reassessed for transferring assistance needed and interviewed by Social Services and unit manager as to offered personal choice preferences with her care related to when to get up to be out of bed when she request.	

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F 242	Continued From page 2 The findings included: Resident #67 was readmitted to the facility on January 6, 2012, with diagnoses including Chronic Atrial Fibrillation, Hypertension, Malnutrition, Diabetes Mellitus, Depression Anxiety, Morbid Obesity, and Healing Stage IV Decubiti. Medical record review of the Quarterly Minimum Data Set (MDS) dated December 31, 2013, revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status exam indicating the resident was cognitively intact. Continued interview revealed the resident required extensive assistance from two persons for activities of daily living and personal hygiene, and was totally dependent with assistance of two persons for transfers. Review of the Mental and Behavioral Health Visit Notes dated November 25, 2013, January 7 2014, and January 21, 2014, revealed, "...wants to get up and out of...room to distract...and help...cope but says staff don't always follow through on getting...up...really needs to get out of...room occasionally because the isolation is feeding...depression...states has asked to get up and out of...room but staff can't seem to find the time...feels discouraged and defeated..." Medical record review of the physicians recapitulation orders dated February 1 through February 28, 2014, revealed, "...Up in chair daily; out of bed daily as per pt (patient) request..." Observation on February 11, 2014, at 10:30 a.m., and February 12, 2014, at 10:00 a.m., in the	F 242	2. Oriented residents needing assistance with transferring have the potential to be affected by the alleged deficient practice. Audits will be done to determine these resident by using BIMS score and they will also be reassess and interviewed for preferences Therefore, staff has offered personal choices of getting out of bed as requested. The licensed nurse will be notified when residents refuse to get out of bed to assure that preferences are being met. 3. In-service/re-education nursing staff by DON, Unit manger, nursing supervisors for Residents choices being honored to get out of bed must be met to ensure for continued compliance. The licensed nurse will be notified when a resident refuse to get out of bed to assure that preferences are being met.	

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F 242	Continued From page 3 resident's room, revealed the resident was in bed. Observation and interview with the resident in the resident's room, on February 11, 2014, at 10:30 a.m., confirmed the resident required assistance and the use of a lift for transfers to get out of the bed. Continued interview confirmed the resident had not been able to get out of the bed as often as desired due to "not enough staff to get me up." Stated, "I am aware of the extra time and attention it takes to get me up because of my size and having to use the lift. They (staff) tell me they will get me up, but they never do." Interview with the Director of Nursing (DON), in the activities room, on February 12, 2014, at 7:45 a.m., confirmed no knowledge the resident had not been assisted to get out of bed when requested.	F 242	4. The Unit Managers or Director of Nursing will review data obtained during ambassador audits, social; services will interview residents 3 times a week x 3months to determine if preferences are met, Social Services will analyze the data and report patterns/trends to the QAPI committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	03/14/14
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to keep the hallways free of odors for two of four hallways. The findings included: Observation during the survey from February	F 253	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." F 253 1. Corrective action has been accomplished for the alleged deficient practice in regards to the 2 rooms identified have been deep cleaned to include mattresses	

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F 253	Continued From page 4 10-12, 2014, of the one hundred hallway, revealed unpleasant, foul odors. Continued observation revealed the unpleasant, foul odors were in two rooms on the 100 hall. Interview with the Director of Nursing on February 12, 2014, at 8:55 a.m., in one of the rooms on the 100 hall, confirmed was aware of the rooms having unpleasant, foul odors due to the facility not able to regularly clean the air mattress used for the residents in the room. Continued interview revealed the resident in one room (private room) was aware of the odor and had asked the facility to hang cloves in the room to help with the odors. Observation during the survey from February 10-12, 2014, revealed the three hundred hallway had a foul odor, and appeared to be from one room. Continued observation revealed the odor was a strong urine smell. Interview with Licensed Practical Nurse #1 on February 12, 2014, at 9:40 am, in the three hundred hallway, confirmed the smell was urine smell coming from the room.	F 253	2. Residents residing in the facility on 100 and 300 hallways have the potential to be affected by the alleged deficient practice. 3. In-service/re-education to staff by administrator, housekeeping supervisor and DON, unit manager, nursing supervisor on reporting any odors immediately to Housekeeping supervisor. The mattress liners will be placed on routine cleaning to coincide with showers and as needed. Mattress Liners will be replaced as needed. 4. Rounds will be done 3 times weekly x 3 months by department heads assigned by administrator to verify current plan and to identify any ongoing concerns The results of these will review in morning meeting Monday though Friday and data obtained will be analyze and report patterns/trends to the QAPI committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	03/14/14
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		

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F 279	Continued From page 5 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to update the care plan for one resident (#67) with concerns of not getting out of bed; one resident (#13) for dialysis access; and one resident (#73) for insomnia for a total of three of thirty residents reviewed. The finding included: Resident #67 was readmitted to the facility on January 6, 2012, with diagnoses including Chronic Atrial Fibrillation, Hypertension, Malnutrition, Diabetes Mellitus, Depression, Anxiety, Morbid Obesity, and Healing Stage IV Decubiti. Medical record review of the Quarterly Minimum Data Set (MDS) dated December 31, 2013, revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status exam indicating the resident was cognitively intact. Continued review revealed the resident required extensive assistance from two persons for activities of daily	F 278	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." F 279 1. Residents #67, #13 and #73 care plans have been reviewed and updated to meet resident needs. 2. Residents receiving dialysis, oriented resident requiring assistance with transfers, and resident with diagnosis of insomnia in facility have the potential to be affected by the alleged deficient practice. Care plans for resident with dialysis, oriented with assistance needed for transfers and those with diagnosis of insomnia will be audited and updated. 3. In-service/re-education to Interdisciplinary team which includes DON, Unit managers, Social services, Activities on developing, revising, updating care plans to meet individual needs of the resident was conducted by the regional director of clinical.	

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F 279	Continued From page 6 living and personal hygiene, and was totally dependent with assistance of two persons for transfers. Review of the Mental and Behavioral Health Visit Notes from the Licensed Clinical Social Worker (LCSW) dated November 25, 2013, January 7, 2014, and January 21, 2014, revealed, "...want to get up and out of...room to distract...and help...cope but says staff don't always follow through on getting...up...really needs to get out of...room but staff can't seem to find the time...feels discouraged and defeated..." Medical record review of the physician's recapitulation orders dated February 1 through February 28, 2014, revealed, "...Up in chair daily; out of bed daily as per pt (patient) request..." Medical record review of the care plan dated October 4, 2013, revealed the physician's order and the resident's request to get out of bed daily was not added to the care plan. Observation on February 11, 2014, at 10:30 a.m., and on February 12, 2014, at 10:00 a.m., in the resident's room, revealed the resident was in the bed. Observation and interview with the resident, in the resident's room, on February 11, 2014, at 10:30 a.m., confirmed the resident required assistance and use of a lift for transfers to get out of the bed. Continued interview confirmed the resident had not been able to get out of the bed as often as desired due to "not enough staff to get me up." Stated, "I am aware of the extra time and attention it takes to get me up because of my size and having to use the lift. They (staff) tell me they	F 279	4. During morning meeting IDT will review new orders and 24-hour report for last 24-72 hours and update care plans as needed. The QAPI committee will evaluate the effectiveness of the above plan for 3 months, and will add additional interventions based on outcomes identified to ensure continued compliance.	03/14/14

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F 279	Continued From page 7 will get me up, but they never do." Interview on February 12, 2014, at 10:35 a.m., with the Minimum Data Set (MDS) Coordinator, in the MDS office, confirmed no knowledge of the LCSW's notes regarding the resident's concerns about not getting up, out of the bed. Continued interview confirmed the resident's care plan had not been revised to reflect the resident's preferences to be out of the bed daily. Resident #13 was admitted to the facility on July 17, 2013, with diagnoses including End Stage Renal Disease, Hypertension, Hyperlipidemia, Depressive Disorder, Diabetes, and Amputation Leg (bilateral). Medical record review revealed the resident had a dialysis access (shunt) in the left upper arm and received dialysis three days a week at an out patient clinic. Medical record review of the care plan dated January 30, 2014, revealed the care plan did not address the resident's dialysis access (shunt) located in the left arm or the standard of practice which requires no needle sticks or blood pressure checks in the arm of the access. Observation on February 11, 2014, at 3:15 p.m., revealed the resident was in the resident's room watching TV. Interview with the Director of Nursing (DON) on February 12, 2014, at 8:40 a.m., in the DON's office, confirmed the care plan did not address the resident's dialysis access in the left upper arm.	F 279		

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F 279	Continued From page 8 Resident #73 was admitted to the facilty on October 1, 2012, with diagnoses including: Osteomyelitis, Muscle Weakness, Hypertension, Renal Failure, Diabetes, and Obstructive Sleep Apnea. Review of the physician's order dated November 7, 2013, revealed trazodone (antidepressant) 25 mg (milligram) PO (by mouth) at 8:00 p.m Medical record review of the care plan updated November 18, 2013, and February 8, 2014, revealed the care plan did not address the resident's insomnia. Interview with the DON on February 11, 2014, at 3:55 p.m., at the main nurses' station, verified the resident was receiving trazodone for insomnia, and was initiated on November 7, 2013. Observation on February 11, 2014, at 4:30 p.m., revealed the resident was in the resident's room watching TV. Interview with the MDS Coordinator on February 11, 2014, at 4:45 p.m., in the MDS's office, confirmed the care plan did not address the resident's insomnia.	F 279		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 441	Continued From page 9 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to change soiled clothing for one resident (#13) of thirty residents reviewed, and failed to prevent cross-contamination during ice pass for two of two ice passes observed. The findings included:	F 441	F441 1. R #13 gown was immediately changed. Ice cart was clean and new ice provided 2. Resident in facility has the potential to be affected by alleged deficient practice 3. In servicing/education was provided to staff by DON, unit manager, nursing supervisor related to prompt changing of soiled items and clothing, proper procedure for passing ice water. 4. Observation walk through will be conducted 3 times a week x 3 months by unit managers and/or nursing supervisor to observe ice pass and residents clothing for any soiled areas. The QAPI committee will evaluate the effectiveness of the above plan for 3 months, and will add additional interventions based on outcomes identified to ensure continued compliance.	03/14/14

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F 441	Continued From page 10	F 441		

Observation on February 11, 2014, at 10:[illegible]5 a.m., of resident #13 resting in bed, revealed a large dark spot on the resident's gown. Continued observation revealed the dark spot was located on the left side just above the waistline, and was irregular in shape, measuring approximately two inches by two inches. Continued observation revealed the spot appeared to be dried blood. Continued observation revealed the resident had a dialysis access in the left upper arm.

Interview with resident #13 on February 11 2014, at 10:15 a.m., in the resident's room, confirmed the resident had gotten blood on the gown from the dialysis treatment the day before (February 10, 2014). Continued interview confirmed the resident returned to the facility between 5:00 p.m. and 6:00 p.m.

Interview with the Director of Nursing on February 12, 2014, at 12:59 p.m., in the Activities room, confirmed the soiled gown was to be changed when the resident returned to the facility on February 10, 2014.

Observation on February 12, 2014, at 7:30 a.m., on the 100 hallway, revealed certified nurse aide (CNA) #5 retrieved a water glass from room 113, held the glass over the ice container, filled the glass with ice from the container, and returned the glass to the resident's room. Continued observation revealed CNA #5 repeated this practice for another resident in room 101 before leaving the hallway.

Interview with CNA #5 on February 12, 2014, at 12:55 p.m., confirmed the resident's water glass was not to be held over the ice container while

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	02/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 filling the glass with ice. Interview with the Director of Nursing on February 12, 2014, at 12:55 p.m., confirmed the resident's water containers were not to be held over the ice container when filling the water containers.	F 441	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the call lights were in working order for three of fifty-one rooms observed. The finding included: Observation with medical records staff member on February 12, 2014, at 10:00 a.m., in the one hundred hallway revealed one call light in one of 14 rooms was not working. Observation of the four hundred hallway, revealed the call lights in two rooms of seventeen rooms were not working. Interview with the medical records staff member at the time of observation confirmed the call lights were not working.	F 463	F463 Call lights in 3 rooms identified were immediately replaced Residents residing in facility have the potential to be affected by this alleged deficient practice. In servicing to staff to timely report any non-working call lights to maintenance by Administrator, DON, Maintenance supervisor. Call lights will be audited 3 times a week x 3 months by department heads on room rounds assigned by Administrator. The QAPI committee will evaluate the effectiveness of the above plan for 3 months, and will add additional interventions based on outcomes identified to ensure continued compliance. The maintenance team will perform weekly call light checks 03/14/14	